COUNTY OF SUFFOLK

ROBERT J. GAFFNEY
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES
Clare B. Bradley, MD, MPH
COMMISSIONER

DIVISION OF COMMUNITY MENTAL HYGIENE SERVICES
THOMAS O. MACGILVRAY, CSW, CASAC
DIRECTOR

MINI-CAMERA Addendum to Application For

Court-Ordered Assisted Outpatient Treatment

Referral Source _____

Relationship to Referred Party _____

Address _____

Address _____

Tel # _____ Fax # _____

Application Date: _____

EMERGENCY CONTACT

Name _____

Address _____

Tel # _____Relationship _____

Is client currently receiving Medicaid? ☐ Yes ☐ Pending ☐ No

Is client currently receiving Medicare? ☐ Yes ☐ Pending ☐ No

DSS Case # _____Medicaid # _____Sequence # _____

Other Ins. _____Medicare # _____ Part ☐ A ☐ B

Is client enrolled in Managed Care? ☐ No ☐ Yes-Program _____

Does client have Rep-payee? ☐ No ☐ Yes
Name _____ Tel # _____

Has client ever applied for or has application been made for any of the following: (Indicate category, status, & amount for each)

a. Category ☐ SSI ☐ PA ☐ SSD ☐ HR ☐ VA Other:_____
(For each box checked above, Code current status as (A)ctive, (I)nactive, or (P)ending)

b. Circle Status [(A) (I) (P)] [(A) (I) (P)] [(A) (I) (P)] [(A) (I) (P)] [(A) (I) (P)]

c. Amount/Month (if known) $_____ $_____ $_____ $_____ $_____ $_____

Type of Residence: Com. Res. ___ Adult Home ___ Rm&Bd ___ Supported Housing ___
DSS Emergency Housing ___ Own Home ___ Other_____

Has client accepted this referral for case management services?: ☐ Yes ☐ No

Please have client sign this Consent for Release of Information

I hereby authorize the periodic release of information necessary to arrange for Case Management services to any Case Management, Mental Health treatment agency or other agencies that may provide services for me. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission for release of information at any time.

My consent to release information to the CAMERA Unit and to any Case Management, Mental Health treatment agency or other agencies that may provide services for me will expire when I am no longer receiving services from such organization, or one year from this date, whichever occurs first.

Signature of Patient/Person Acting for Patie	Relationship	Date Signed	Signature of witness	Title	Date Signed
_____	_____	_____	_____	_____	_____